

SUPPLEMENTAL INVESTIGATOR DATA FORM

Date (MM/DD/YYYY):

___/___/___

Sections 1 – 11: REQUIRED INFORMATION (collected for all investigators participating in NCI-sponsored clinical trials)

1. Investigator Name (Last, First, Middle, Suffix):			2. Degree(s):		3. NCI Investigator No.:				
4. Date of Birth (MM/YYYY): ___/___/___		5. Provider No. (UPIN):		6. Are you currently licensed to practice medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO					
7. Primary Specialty Practice(s):		Board Eligible:		Board Certified:		Board Eligible:		Board Certified:	
Anatomic and/or Clinical Pathology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Obstetrics and Gynecology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Clinical Genetics		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Orthopedic Surgery		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Colon and Rectal Surgery		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Otolaryngology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Dermatology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Pediatric Hematology-Oncology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Diagnostic Radiology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Pediatrics		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Family Practice		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Psychiatry		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Gastroenterology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Public Health and General Preventative Medicine		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Gynecological Oncology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Radiation Oncology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Hematology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Surgery		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Internal Medicine		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Surgical Oncology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Medical Oncology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Thoracic Surgery		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Neurological Surgery		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Urology		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Neurology		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		Other _____		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
8. Have you received training in:		Completion of this training is mandatory for all NCI-registered investigators.							
"Protection of Human Research Subjects"?		<input type="checkbox"/> YES <input type="checkbox"/> NO		DATE COMPLETED (MM/YYYY): ___/___/___					

In section 9 – 11, use this side to either enter new information or view current information.

In sections 9 – 11, use this side to make changes to current information only.

9. Office Address: The office address will be used for receipt of all official correspondence.

Institution: _____
 Internal Office: _____
 Street Address: _____
 Street Address: _____
 City: _____
 State/Province: _____
 Zip/Postal Code: _____
 Country: _____
 Office Phone No.: _____
 Office FAX No.: _____
 Office E-mail Address: _____

Institution: _____
 Internal Office: _____
 Street Address: _____
 Street Address: _____
 City: _____
 State/Province: _____
 Zip/Postal Code: _____
 Country: _____
 Office Phone No.: _____
 Office FAX No.: _____
 Office E-mail Address: _____

10. Primary Shipping Address: The primary shipping address will be used for receipt of all CTEP-supplied investigational agents.

Institution: _____	Institution: _____
Internal Office: _____	Internal Office: _____
Street Address: _____	Street Address: _____
Street Address: _____	Street Address: _____
City: _____	City: _____
State/Province: _____	State/Province: _____
Zip/Postal Code: _____	Zip/Postal Code: _____
Country: _____	Country: _____

Shipping Designee: Provide name of shipping designee (preferably a pharmacist) approved to order and receive CTEP-supplied investigational agents.

Shipping Designee Name: _____	Shipping Designee Name: _____
Shipping Designee Phone No.: _____	Shipping Designee Phone No.: _____
Shipping Designee FAX No.: _____	Shipping Designee FAX No.: _____
Shipping Designee E-mail Address: _____	Shipping Designee E-mail Address: _____
<p>NCI USE ONLY: <input type="checkbox"/> PSD <input type="checkbox"/> SD <input type="checkbox"/> IA</p>	

11. Ordering Designee(s): Provide name(s) of ordering designee(s) approved to order CTEP-supplied investigational agents. **Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied investigational agent must be signed by either the investigator, the authorized shipping designee (from item #10), or an ordering designee (from item #11). An ordering designee must use the primary shipping address (from item #10).**

<p>A. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>	<p>A. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>
<p>B. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>	<p>B. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>
<p>C. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>	<p>C. Ordering Designee Name: _____</p> <p>Ordering Designee Phone No.: _____</p> <p>Ordering Designee Fax No.: _____</p> <p>Ordering Designee E-mail Address: _____</p>

- Please be sure you have also included:
1. Completed FDA Form 1572 with original signature.
 2. Current Curriculum Vitae (CV).
 3. Completed Financial Disclosure Form with original signature.

I certify that the information on this "Supplemental Investigator Data Form" is true and correct to the best of my knowledge.

Investigator: _____ Date: _____
(Signature)

Section	INSTRUCTIONS FOR COMPLETING THE "SUPPLEMENTAL INVESTIGATOR DATA FORM"
1.	Investigator Name: Provide legal last name, first name, middle initial or name, and suffix (if applicable).
2.	Degree(s): Provide degree(s) (e.g., M.D., D.O., foreign M.D. equivalent).
3.	NCI Investigator No.: Provide the unique NCI investigator number assigned to the investigator by the Pharmaceutical Management Branch (PMB), CTEP, DCTD, NCI at the time of initial registration. <i>(If an investigator has never registered to participate in NCI-sponsored clinical trials, leave field blank. An NCI Investigator No. will be assigned by the PMB as part of the registration process.)</i>
4.	Date of Birth: Indicate the investigator's date of birth (in MM/YYYY format).
5.	Provider No. (UPIN): Indicate the investigator's Unique Physician Identification Number (UPIN). <i>This information is optional and is for internal reporting only.</i>
6.	Medical License: Indicate if the investigator is currently licensed to practice medicine.
7.	Primary Specialty Practice(s): Indicate the investigator's primary specialty practice(s). Board Eligible: Indicate if the investigator is eligible for Board Certification in the primary specialty practice selected. Board Certified: Indicate if the investigator is Board Certified in the primary specialty practice selected.
8.	Investigator Training: Indicate if the investigator has completed the NIH-mandated training in the protection of human research subjects, including date completed (in MM/YYYY format). If needed, additional information and online training are available at http://ohsr.od.nih.gov/cbtl/ . The online training takes approximately one hour to complete. <i>Completion of human research subjects protection training is mandatory for ALL NCI-registered investigators.</i>
9.	Office Address: The office address will be used for receipt of all official correspondence (e.g., annual registration and protocol documents). Include institution, internal office, street, city, state/province, zip/postal code, and country. Office Phone No.: Provide daytime phone number at which the investigator can be reached during normal business hours, including area code. Investigators from outside the United States should also include the country code. Office Fax No.: Provide Fax number at which the investigator usually receives faxes, including area code. Investigators from outside the United States should also include the country code. Office E-mail Address: Provide E-mail address at which the investigator usually receives e-mail. This address will be used to send information regarding protocols and general information for the investigator.
10.	Primary Shipping Address: The primary shipping address will be used for receipt of all CTEP-supplied investigational agents. Include institution, internal office, street, city, state/province, zip/postal code, and country. Shipping Designee: Provide name of shipping designee (preferably a pharmacist) approved to order and receive CTEP-supplied investigational agents. <i>Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied investigational agent must be signed by either the investigator, the authorized shipping designee (from item #10), or an ordering designee (from item #11).</i> Shipping Designee Phone No.: Provide daytime phone number at which the shipping designee can be reached during normal business hours, including area code. Shipping designees from outside the United States should also include the country code. Shipping Designee Fax No.: Provide Fax number at which the shipping designee usually receives faxes, including area code. Shipping designees from outside the United States should also include the country code. Shipping Designee E-mail Address: Provide E-mail address at which the shipping designee usually receives e-mail. This address will be used to send information regarding protocols and general information for shipping designees.
11.	Ordering Designee(s): Provide name(s) of ordering designee(s) approved to order CTEP-supplied investigational agents. <i>Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied investigational agent must be signed by either the investigator, the authorized shipping designee (from item #10), or an ordering designee (from item #11). An ordering designee must use the primary shipping address (from item #10).</i> Ordering Designee Phone No.: Provide daytime phone number at which the ordering designee can be reached during normal business hours, including area code. Ordering designees from outside the United States should also include the country code. Ordering Designee Fax No.: Provide Fax number at which the ordering designee usually receives faxes, including area code. Ordering designees from outside the United States should also include the country code. Ordering Designee E-mail Address: Provide E-mail address at which the ordering designee usually receives e-mail. This address will be used to send information regarding protocols and general information for ordering designees.